Final Submission

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Reflective case study regarding a significant issue, particularly focusing on the professional, ethical and legal principles of nursing.

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The pseudonym Sarah has been given to the service user in order to ensure confidentiality within this assignment.

Reflection is a fundamental part of nursing care (Atkins and Murphy, 1993, p.1188) as it allows us to contemplate our previous actions, thoughts and memories in order to make sense of them (Taylor, 2000, p.3). In this assignment, I will be utilising the tool reflection-on-action; a retrospective activity that will allow me to inspect my use of self in a particular situation with a service user. The use of this reflective activity will also provide a bridge between practice and theory (McCaughterty, 1991, p.514), allowing me to inspect how I used theory, law and policy correctly and allowing me to recognise areas I need to work on for the future, ensuring I act in best-practice.

Within this essay, I will use the Boud et al's model of reflection (1985), which was further developed by Driscoll in 1994. During my three years as a student nurse, I have utilised this model numerous times, which has increased my confidence and competence with its three stages. The stages can be used as prompts to aid the user to reflect effectively; they compromise of the 'what' section; what happened in the situation? 'So what'; this allows for the user to divulge into their actions and feelings further, applying relevant theory, evidence and policy to support it, and finally 'now what'; allows the user to make a conclusion about the reflection, and make an action plan to improve their practice in the future. Evidence suggests that this model of reflection is beneficial, as it assists the person using it to structure the reflection in a meaningful way (Stonehouse, 2015, p.238), especially as it allows the user to "collect and collate the evidence" relevant to the topic (Dyke, 2009; Wisker, 2007 cited in: Regmi and Naidoo, 2013, p.34). However, this model has been criticised as it can be seen as too simplistic (Howatson-Jones and Standing, 2010, p. 60) and important areas of reflection can be missed with this model if the cue questions are not used. It is important to note that the

title of this assignment has implications on this reflective exercise. This essay is essentially a discussion of the professional, legal and ethical aspects of the situation, and therefore certain aspects of Boud et al's model (1985) and Driscoll's model (1994) have been purposely omitted. This is to ensure relevance and to provide in-depth discussion of the applicable points.

Whilst on placement on an acute ward in the North of England, a specific event occurred that I feel reflecting on would be beneficial. It happened one morning when I was in the nurses' office completing paperwork, and I heard Sarah shouting my name and asking to talk to me. I quickly attended to Sarah and approached her, offering a private room for our conversation. However, Sarah refused to go into a private space and immediately reported that other staff members were disregarding her human rights by not taking her down to the courtyard for a fresh air break. I commented that all staff members were busy at that time, but when someone was available she would be escorted outside, and I apologised for the delay. Sarah then began to be verbally abusive at me and her physical stance became intimidating. I then told Sarah that she would need to compose herself before being escorted off the ward as being verbally abusive to others was not an appropriate demeanour, however she continued to be aggressive. Therefore, I walked away from Sarah as I felt intimidated by her conduct, and after approximately ten minutes she managed to calm herself down without the assistance of medication or staff intervention. Whilst this situation was unfolding, other staff members were present but did not intervene despite Sarah's aggression towards me, which made me feel unsupported by the nursing team. Please see Appendix 1 for a full description of this situation.

This incident left me feeling uncomfortable with my actions as I wondered whether I could have handled the situation in a way to facilitate de-escalation, which would have promoted Sarah to continue to converse in a more appropriate manner. I felt that I was experiencing a moral dilemma immediately after this situation; did I act in the best interests of Sarah, respecting her rights to fresh air? Or did I ignore Sarah's best interests and focus on protecting myself against the verbal abuse? The number of questions that arose from this situation have left me curious as to whether I acted in a professional, ethical and legal manner, which I will further explore these issues in this assignment.

On reflection, I still wonder whether I acted in a beneficent or maleficent way. The Nursing and Midwifery code states that we must "treat people with kindness, respect and compassion" (2015, p.4) and so ending the conversation with Sarah could be seen to be uncompassionate and against our professional nursing values. Despite this, as nurses we are entitled to "be able to carry out [our] professional duties in a safe working environment… without violence or intimidation" (The Royal College of Nursing, 2012, p.2), and therefore removing myself from the intimidating situation is a legitimate and justifiable action. It can be further argued that I acted in the most beneficent manner towards Sarah because removing myself from the situation gave Sarah the space to de-escalate, re-gather her thoughts and act in a more appropriate manner, which was also the least restrictive intervention (National Institute for Health and Care Excellence (NICE), 2014, p.29). By allowing Sarah to de-escalate herself, the other service users had a better ward environment as no restraint was needed which can be distressing for other service users to witness. This then leads onto the ethical theory of utilitarianism, which suggests that "any action is morally right if the consequences of that action are more favourable than unfavourable" (Barker, 2011, p.21). The ward housed a number of service users who are entitled to "receive the nursing care they need" (NICE, 2014,

p.9), and therefore, as Sarah was not a risk to herself or others during her verbally aggressive outburst, the act of walking away from her allowed other service user's to utilize my time, which facilitated the continuation of building the therapeutic nurse-client relationships with other service users (Bowers, 2014, p.499), ensuring we were "deliver[ing] the fundamentals of care effectively" (NMC, 2015, p.4) It also allowed me to continue my other tasks that I was undertaking that had upmost importance at that time. Therefore, a utilitarianism argument would be that I acted beneficently for all individuals on the ward.

On numerous occasions prior to the situation I encountered with Sarah, I had witnessed other staff members privately comment on how they found her difficult to work with due to her inherent demands and the possible aggression that she displayed if these were not met. I had also experienced this first hand on previous shifts and therefore when I heard Sarah calling my name over the nurse's station, I approached her with the preconception that she would be demanding and possibly aggressive. Haas et al comment that a patient may be labelled a 'difficult patient' if they engage in a power struggle with healthcare professionals (2005, p.2063) which could clearly be seen through Sarah's dominant nature and her belief that we should facilitate her requests immediately. At the time of the situation, I found it difficult to maintain a professional stance when conversing with her as I felt intimidated by her attitude and posture. However, I did manage to maintain a professional attitude and continued to treat Sarah with the "respect, kindness and compassion" (The Nursing and Midwifery Code (NMC), 2015, p.4) that all service users are entitled to.

During this situation I felt that my use of the 6 C's were being exhausted by Sarah due to her rude and demanding behaviour, as I noticed my care and compassion were significantly reduced towards her. The 6 C's are values that nurses must implement in their caregiving in

order to provide better care for patients (Farenden, 2014), and consist of; care, compassion, competence, communication, courage and commitment (NHS Commissioning board, 2012, p.13). It was apparent that my co-workers shared these feelings of exhaustion towards Sarah, which could be seen through their avoidance of intervention when she was verbally aggressive towards me. At the time, this left me feeling unsupported by the team, however after discussion with the staff members on that shift, they explained that they purposely did not intervene for the risk they may act un-compassionately towards her. On reflection, I can see how these reactions to Sarah were the start of compassion fatigue, a "job-related distress that outweighs job satisfaction" (Sheppard, 2016, p.53) that is a response to "interpersonal interactions" (Thompson et al, 2014, p.59).

It could also be argued that the feelings of compassion fatigue I was experiencing were in fact countertransference. Gelso and Hayes defined countertransference as "the therapists' reactions to clients based on their unresolved conflicts" (2007, cited in Tishby and Wiseman, 2014, p.361). I have previously had the experience of being a service user with my freedom of fresh air breaks being controlled by staff members, and therefore I was able to relate to Sarah's frustration at her situation. At the time of the interaction with Sarah, I was unaware that I shared the same view of psychiatric ward settings feeling restrictive, which in turn meant that I over empathized with her. It could therefore be said that I am still developing towards becoming a qualified nurse as I was unaware of "how personal values, beliefs and emotions impact on practice" (NMC, 2010, p.23). However, it can also be argued that the use of my own experiences helped me to work with more effectively with Sarah, as I was seemingly more willing to complete her requests than my co-workers due to my personal understanding of her situation. Other staff members later commented that they would have walked away from her as soon as she began to be verbally aggressive, and when asked how I

managed to maintain a calm manner towards her for the duration of the interaction, I explained that it was the result of me empathising with her frustration, although I did not divulge into why I could empathize. Zepf et al comment that although an empathetic understanding and a countertransference reaction are two separate responses during interaction, empathy can be employed through countertransference. They further say that empathy is a "perspective whereby the analyst employs current countertransference reactions for an understanding of the patient's inner life" (2008, p.741).

Beauchamp and Childress identified four key areas of ethical consideration that all healthcare professionals should practice by, which are beneficence, non-maleficence, autonomy and justice (1994). The principle of autonomy conveys that healthcare professionals should "preserve people's ability to decide for themselves" (Holland, 2004, p.15). It can be seen that I utilised this ethical principle within the situation by giving Sarah the choice to talk in a private room to maintain her confidentiality. Sarah denied this option which she was entitled to as she had the right to decide for herself. Beneficence can be defined as an act of kindness through helping others (Kinsinger, 2009, p.44), which can be seen through my immediate response to Sarah, postponing the task I was currently doing until I had addressed Sarah's request of speaking to me. Beneficence can also be seen through the organisation of Sarah's fresh air break; although I could not be organise it instantaneously, I ensured her request was completed at a more appropriate time. Non-maleficence is the act of not harming others (Goldenberg, 2009, p.61) which can be seen through my ability to assess Sarah's risk to herself and others. Although Sarah was presenting as aggressive, Sarah's previous history of this behaviour showed that she was able to calm herself down, which was the least restrictive option and therefore this choice was non-maleficent. Finally, justice can be defined as "fair, equitable, and appropriate treatment in light of what is due or owed" (Beauchamp and

Childress, 1994, p.327), which I conveyed justice towards Sarah by ensuring her request would be met.

Sarah was detained under section 3 of the Mental Health Act (MHA) because she was a risk to herself and others, and in order to assess and treat her mental illness (1983). The use of the Mental Health Act (1983) took primacy because she was unwilling to consent to treatment (Griffith and Tengnah, 2012, p.642), and it was in the consultant psychiatrist, second-opinion doctor and social workers view that she needed treatment; therefore the section was placed on her in order for us to legally treat her mental illness. Sarah was initially placed under a section 2 when she was admitted to the ward, however this was changed to a section 3 once the doctor's had assessed Sarah over the 28 day period of a section 2's holding powers. Further, in order to ensure the legal treatment of Sarah with medicines, the documents called T2 and T3 were put in place for Sarah, which are documents completed by her responsible clinician and a second-opinion doctor (MHA, 1983) who agreed that she needed the medications to aid her recovery. Although Sarah was unwilling to accept treatment because she did not have insight into her mental illness, it was assessed and documented that Sarah did have capacity. This meant that she was able to "understand the information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision [and] communicate [that] decision" (Mental Capacity Act, 2005). Therefore, the use of the Mental Capacity Act (2005) and the Deprivation of Liberty safeguard (DOLs) was not appropriate in Sarah's case. Due to Sarah's detention under a section 3 of the MHA (1983), it was a legal requirement for staff to ensure Sarah is aware of her rights under this section, and therefore staff had to ensure that she was aware of these by reading her the 132 rights every two weeks to ensure Sarah was aware of these. These rights included having an advocate, the

right to request a managers hearing and a tribunal which allow her to appeal against her section.

It was evident from Sarah's comments and use of the appeal procedures that Sarah was unhappy with the section 3 of the MHA 1983. It could be argued that the restriction to Sarah's living circumstances caused by her section 3 of the MHA caused continual frustration towards staff members, as we were the one's implementing the measures of her section. The responsible clinician for Sarah determined that she was not safe to go off the ward on her own, therefore Sarah had to be escorted off the ward with a staff member. Sarah was undeniably deprived of her liberty of freedom due to her detention under the MHA, however this was a lawful deprivation and in line with the Human Rights Act (1998, section 1 article 3). It seems to be common for service users to feel deprived of their liberties if they are restricted to how often they can go outside for fresh air breaks, with one service user detained on a section 3 of the MHA commenting "restrictions of the smoking breaks and smoking ban constitute to a worrying denial of civil liberties and human decency" (The Care Quality Commissioning Board, 2013/14, p.6). In the situation I encountered with Sarah, she became increasingly agitated and frustrated due to my responses that she could not leave the ward for her entitled fresh air breaks when she wanted them. Sarah has previously been dismissive of the explanation as to why it is important for staff to escort her off the ward, and she fully believes that we were acting against her rights.

Reflection on this situation has not only been a beneficial exercise in understanding my actions towards Sarah, but it has also allowed me to better understand my use of self. Before this activity, I was unaware of my own feelings of containment about psychiatric wards, which could have had a detrimental impact on my practice should this have been left

unnoticed. This is because it could have led to further countertransference with other patients and further, compassion fatigue. Although I am not fully confident about how to leave my personal experiences behind, this reflection has allowed me to notice the issue which has given me the opportunity to further work on knowledge of myself in the future. I am also aware of how compassion fatigue can have an impact on a whole team, especially when there seems to be a power struggle between the professionals and the service user. It would be beneficial for me to further look into how to manage compassion fatigue when a whole team seems to be suffering from it, however I feel that is a managerial problem that I may look into later in my career. I feel in the future should I experience compassion fatigue again it would be useful for me to utilise supervision time with my mentor or manager. Further, I feel that although I have been able to identify that I was experiencing countertransference with Sarah, I was also experiencing compassion fatigue due to her demanding and rude behaviour. I feel that on reflection this was probably enhanced by the fact other staff members were feeling the same, and so I ended up conforming to the majority (Milgram, 1963). This is often the case in a close working proximity, and I feel I need further understanding of this in order to combat it should I notice myself conforming in the future.

After deliberating my initial moral dilemma, I feel I have come to the conclusion that I acted in a beneficent way. I ensured the management of Sarah's aggressive outburst was managed in the least restrictive manner whilst ensuring the safety of Sarah, the other staff members, service users and myself. I made Sarah aware that I had heard her request and would facilitate it when she was acting appropriately, despite walking away from her when she was being verbally aggressive, which was within my rights as it was the local NHS trust's policy that they had a 'zero tolerance policy' towards violence and aggression (Trust, 2015). Finally, I feel that the legal aspects of Sarah's detention and treatment on the ward were lawful and in

line with best practice, despite her dissatisfaction with its constraints. I feel I need to further enhance my practice by reading around the Mental Health Act (1983) and Mental Capacity Act (2005) in order to follow its principles thoroughly, and also to be able to explain them to service users in the future should they ask.

Overall, this reflection has enabled me to answer the initial questions I asked at the beginning of this reflective process, and I can now confidently say that I do feel I facilitated Sarah's de-escalation effectively, I did respect Sarah's rights to fresh air and I did act in a professional, ethical and legal manner.

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Appendices 1

Sarah was presenting with an acute phase of mania, which could be seen through her flight of ideas; pressure of speech; aggression; irritability; poor sleep and delusions of grandeur. She has in-depth knowledge of mental health services and thus became very demanding as to what she was entitled to, such as going out for fresh air breaks every hour, manager's hearings and tribunal meetings. Due to Sarah's chaotic presentation, she was placed under section 2 of the mental health act and had to be escorted off the ward at all times by a member of staff.

Sarah's demanding behaviour made it increasingly difficult to nurse her, as she was unwilling to listen to professional advice or negotiate, and she would become verbally aggressive when she was asked to wait or told no. Sarah had learnt to ask numerous staff for the same request, as this way she was hoping to get the answer she wanted from someone. This behaviour also meant that other service users were not receiving the level of care that they needed as Sarah was taking up the majority of staff time.

During the incident described in this assignment, Sarah had already asked other staff members to take her downstairs for a fresh air but they all told her they were busy and would accommodate this request when possible. Sarah had then asked me the same request in the hope that I would offer her an alternative answer, but due to my unanimity with the other staff members she became frustrated from being told no, and so became verbally aggressive towards me. Other staff members were present and witnessed Sarah's aggressive language and behaviour towards me, however none of them intervened, which led me to feeling unsupported by the other staff members.

All of the staff members had previously reported that they were finding it increasingly difficult to nurse Sarah because she was so rude when her needs were not met, and a lot of them had asked not to be her allocated worker on shift because of these struggles. When I asked about them not supporting me when she was being aggressive, they commented that they were sorry I felt unsupported but that they felt as though intervening would have been more detrimental as they feel very close to shouting back at her.